**IRMS:** Hepatitis Vaccine Project **Facility** _____

**Complete ALL information for each entry and please print legibly. Fax forms bi-weekly to 558-6478**

**Patient** _____ _____ _____
*First* *Middle* *Last*

**Phone** _____ **DOB** _____ **Gender: M** ____ **F** ____

**Physical Address** _____ **County** _____

**City** _____ **State** _____ **Zip** _____

***Patient Race*** __Am. Indian or Alaskan Native
__Native Hawaiian or Other Pacific Islander
__White __African American __Asian

***Patient Ethnicity***
__Hispanic __Non-Hispanic
__Unknown

| | | | | | |
|---|---|---|---|---|---|
| **Vaccine Type** | | | | | |
| **Vaccination Date** | | | | | |
| **Manufacturer/ Lot Number** | | | | | |
| **Lot Expiration** | | | | | |

By signing the consent below, I certify that I received the Vaccine Information Statement for the vaccine I will receive. I understand the risks and benefits of vaccination and have been given the opportunity to ask questions about the vaccine.

*Patient Signature _____Date_____/_____/_____

Signature of Vaccinator _____ Date____/_____/_____

*Patient Signature _____Date_____/_____/_____

Signature of Vaccinator _____ Date____/_____/_____

*Patient Signature _____Date_____/_____/_____

Signature of Vaccinator _____ Date____/_____/_____

*Patient Signature _____Date_____/_____/_____

Signature of Vaccinator _____ Date____/_____/_____

**Transferred or Released on Date: _____** **Next Dose Due: _____**

**Refer to: _____County Health Department Phone #: _____**

**Transferred to:_____ _____ Phone #_____**

Submit to: WVDHHR/BPH STD Program, 350 Capitol St. Room 125, Charleston, WV 25301 or Fax (304)558-6478